KENTUCKY HEALTH BENEFIT EXCHANGE
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Information and FAQs for Assisters/Agents and General Outreach

What do Kentuckians need to know about OEP 5?

- **It is shorter**

  Open Enrollment dates are November 1, 2017 to December 15th 2017. Consumers will only be able to apply and enroll during this time.

- **Consumers may be cross-walked into another plan**

  If the consumer is enrolled in a plan that will no longer be available for the 2018 plan year, the Marketplace will select a plan to crosswalk their enrollment for 2018. Consumers are encouraged to still take an active role in reviewing plan options and actively selecting a plan despite the crosswalk.

- **Consumers may qualify for an SEP**

  Consumers who are enrolled in a plan that will no longer be available in the Marketplace will qualify for a Loss of Coverage Special Enrollment Period. The **Healthcare.gov** application asks if the consumer "lost *qualifying health coverage in the last 60 days".* To qualify for the special enrollment they must if you answer that you lost coverage.

- **These SEP Consumers must indicate on their application that they are losing coverage**: Applications must be updated to indicate a loss of coverage with an ending date of December 31, 2017. This will allow them a January 1, 2018 start date if they enroll by December 31, 2017. They will have 60 days from December 31, 2017 (until March 1, 2018) to enroll in a new plan, however, they will have a gap ion coverage if they wait that long.

    - Enroll by December 31, 2017 for coverage starting January 1, 2018
    - Enroll in January for coverage starting February 1, 2018
    - Enroll in February for coverage starting March 1, 2018
    - Enroll on March 1, 2018 (**last day to enroll**) for coverage starting April 1, 2018

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- **Consumers will be passively enrolled.**
    - For consumers who are auto re-enrolled, the amount of financial assistance they receive depends on the most recent information available to the Marketplace. It is a good practice for consumers to review the information on their marketplace application.
    - It is important for consumers to review the plan they will be auto enrolled into to make sure it meets their needs.

- **Rates may increase but tax credits may increase as well.**

  Get an estimate at https://www.healthcare.gov/lower-costs/

- **Agents and Assisters are still available for in person help.**

  The search tool on HealthCare.gov directs the public to Kentucky's search tool. Please ensure your contact information is up-to-date within your dashboard.

- **Kentuckians can only get the tax credit, called APTC or Advanced Premium Tax Credit by enrolling through HealthCare.gov.**

  The only way to know the APTC a consumer will receive is to complete the HealthCare.gov application and get an eligibility determination. Tax credits are only available for Marketplace plans.

- **Medicaid program or application process has not changed.**

    - If a person is enrolled in Medicaid, they do not need to do anything until their renewal date.
    - If they are Medicaid eligible, they can apply anytime during the year. Medicaid does have an open enrollment period during which enrollees may change their MCO. Medicaid open enrollment dates are from October 16, 2017 to December 15, 2017.
    - Enrollees must report changes to their address, or changes in family size or income or risk losing coverage. Updates can be made via *benefind.ky.gov.*

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FAQs

How will consumers get information?

- HealthCare.gov and Issuers are sending notices.
- KHBE will use
  - postcards
  - text messaging
  - email messaging
  - social media
  - Public Service Announcements
- Healthcare.gov website
- Federal Marketplace Call Center 1-800-318-2596
- Call center has state specific information for Kentuckians. 24/7
- KHBE.ky.gov
- Kentucky Health Benefit Exchange Contact Center 1-855-459-6328
- Agents and Assisters

When is the Open Enrollment Period for Medicaid?

- Open Enrollment for Medicaid runs October 16 - December 15.
- Medicaid's Open Enrollment is a period of time when enrollees can change their MCO for any reason.
- If the member does not want or need to make any changes they do not have to do anything during this Open Enrollment Period. Their plan will automatically renew.
- To change MCOs enrollees can call 1-855-446-1245. For languages other than English, call 1-800-635-2570.

What happens if someone applies on the FFM during open enrollment, is found assessed for Medicaid, but is then determined by the state, not eligible for Medicaid, after open enrollment ends?

That applicant must return to the HealthCare.gov application and **report a change in circumstances**. They will indicate on the application that they were denied Medicaid/CHIP. This will allow them to possibly qualify for a tax credit and select a plan outside of open enrollment.

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How long will returning clients have to shop for plans before they are "cross-walked" to an alternate plan if their 2017 plan is no longer available?

Consumers will be cross-walked into a new plan when Open Enrollment begins. They can still shop for other plans, make a plan selection other than the plan selected for them, and enroll in a different plan during their Enrollment period.
These consumers can enroll through December 31, 2017 for January 1, 2018 coverage.
Consumers who qualify for the Special Enrollment period due to their 2017 plan no longer being available will have until March 1st to make a plan selection, but waiting until that date will create a gap in their coverage.
Some consumers may not be automatically cross-walked and will need to actively select a plan for 2018.

How does the FFM determine which plan the client will be "cross-walked" into if their current plan is no longer available?

There is a plan hierarchy used by HealthCare.gov to determine the closest matching plan available.

Can we get a crosswalk of plans assigned to new plans? For example: if in Anthem's "xyz1000" for 2017, consumer would be cross-walked to "CS1234" for Carecource in 2018?

If that information becomes available, we will share with the Assister groups as a resource.

What is the best and fastest way for a client to get help troubleshooting an FFM enrollment?

The HealthCare.gov contact center can be reached at 1-800-318-2596. They can assist consumers with technical, application, and enrollment issues. The call center will often encourage consumers to work first with their issuer when appropriate. If an issue needs further escalation, and depending on the issue to be resolved, the contact center or an issuer is the only way for a case to be submitted into the HICS (Health Insurance Caseworker System).

How can an Assister be authorized to speak on behalf of a client? How long can that last?

For Call Center purposes only, a consumer can designate an individual as a third-party representative to communicate with the Marketplace Call Center on the consumer's behalf.
To do so, the consumer can **call the Marketplace Call Center with her third party representative and give verbal authorization for the third party representative to speak on her behalf**.
Note that this verbal authorization allows an individual to act as a third-party representative for Call Center purposes only is **not** the same as a formal designation of an authorized representative, which occurs when a consumer chooses someone to act, rather than only communicate, on her behalf during interactions with the Marketplace.
Instead, this designation of an assister as a third-party representative allows the assister to facilitate communication with the Call Center for a consumer, when the consumer otherwise cannot or chooses not to communicate with the Call Center herself. The major difference between allowing an assister to

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act as a third-party representative and the designation of an authorized representative is that acting as a third-party representative does not allow the assister to make decisions on behalf of the consumer or pick a plan for a consumer

Verbal Authorization allows an in-person assister to communicate with the call center without the consumer on the phone line after the initial verbal authorization has been granted.

As an example: Verbal Authorization was granted to an Application Assister, two days later the consumer decides they want a different plan selection and calls the Application Assister. The Application Assister with verbal authorization **may call the call center without the consumer present** to communicate the plan selection change. This could apply to income changes that need to be communicated, follow up on documents submitted for DMI, etc.

As long as the in-person assister is able to pass disclosure (meaning they can give the consumer's full name, date of birth, and two other pieces of information such as SSN, app ID, etc) and the verbal authorization is on file and not expired, the Call Center Representative can speak with the in-person assister without the consumer being on the line

This authorization **can last for up to one year** unless the consumer calls back to remove the authorization.

What is the timeline for the SEP available to anyone displaced from his or her current QHP carrier? What is the deadline for 1/1 start? 2/1 start? 3/1 start?

Consumers who are/were enrolled in a plan through HealthCare.gov that will not be offered for the 2018 plan year will qualify for a Loss of Coverage SEP. This SEP allows 60 days from the loss to select and enroll in a plan.

It is EXTREMELY important to know that the HealthCare.gov application will ask if someone in the application will lose qualifying health coverage in the next 60 days (or if they have lost it in the past 60 days). **Consumers will qualify for the special enrollment if they answer yes to the question and enter the date of the loss of coverage.**

Please make sure the consumer is within the 60-day time period allowed, that he/she selects the correct qualifying event reason, and that he/she enters the coverage end date. This will ensure that the new plan will be effective the first day of the month following the enrollment month avoiding a gap in coverage.
It is highly encouraged for clients to complete their enrollment by December 31st 2017 to avoid any gap in coverage.

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Is APTC still being offered? Can the prices change after enrolled?

There has been no change to the availability for Tax Credits for plan year 2018.
Tax Credit amounts depend on the Second Lowest Cost Silver Plan (SLCSP) and may increase or decrease for a consumer in 2018 depending on their income, family size and other factors.

Premium amount will not change during the year, however, tax credit eligibility may change for consumers when they report changes such as income increases.

Will changes to the Cost Sharing Reduction reimbursement create higher costs for enrollees?

Despite the recent decision by the federal government to stop reimbursements to insurance companies, Kentucky members will not see any change in their health costs for the remainder of 2017 and the rates and out-of-pocket costs will not be affected.

The effect of the federal government's decision is as follows: Insurers get less money for helping low-income people with out-of-pocket costs on silver plans; premiums on silver plans increase more to compensate; and that forces the federal government to increase all APTC based subsidies to help further with those premium increases.

Are the plans good for the entire 2018 year?

Plans purchased on the exchange will be effective for the entire calendar year unless a consumer does not pay their premium or cancels their plan.